EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-866-607-2360

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

PO Box 20310
Lehigh Valley, PA 18003

Important: Please enter all dates in mm/dd/yyyy format. Return form to: Cigna address above, Fax 1-800-440-0856, Email: bethlehemmail@cigna.com

Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.

Employer: Sun Health Employee Services LLC Policy(s) VDT963218 VDT963219

Class: _____ Location: 0000 Date of Hire: _____ Annual Salary: _____ Verified By: _____

Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) _____

	VDT963218	VDT963219
DISABILITY AMOUNT TO BE UNDERWRITTEN		

EMPLOYEE SECTION

Employee Name (first, middle, last) _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone _____ ID # _____ Birthdate _____ Gender: ☐ M ☐ F

IMPORTANT
Please complete each section that follows.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee info in this section if you are applying for Disability Insurance more than 31 days of becoming eligible due to a life status change or during an ongoing enrollment event.

Height and Weight Information

Employee Height ____ft.____in. Weight _____lbs.

Please indicate your answers for each question in this section by checking the Yes or No box for the question.

	Within the last 5 years has the proposed insured been: diagnosed with any of these conditions; told by a medical professional he/she has or may have any of the conditions; or been treated by a medical professional for any of the conditions shown below? *Please note:* Applicant does not have to disclose positive HIV status if symptoms of the disease have not developed.	Employee Yes	Employee No
A.	A heart attack or stroke?		
B.	Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?		
C.	Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?		
D.	HIV infection or AIDS?		
E.	Diabetes, Hepatitis C or Cirrhosis of the liver?		
F.	Alcohol or drug abuse or dependency?		
G.	Anxiety disorder, Bipolar Disorder or Depression?		
H.	Chronic Fatigue, Fibromyalgia or Multiple Sclerosis?		
I.	Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?		
2.	Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?		

Name _____ Social Security #_____

AGREEMENTS AND AUTHORIZATION

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original. I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request. I understand that the info will be used to assess my request for insurance. I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law. I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance. I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Sign Here _____ _____
Employee's Signature *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

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